Washington State Health Care Authority
Prescription Drug Program
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FIRST DRAFT Minutes of the September 15, 2004 P&T Meeting
[Subject to approval by the Committee at the December 15, 2004 meeting]

Committee Attendance:
Daniel Lessler, M.D. (Chair)
Carol Cordy, M.D. (Vice Chair)
Robert Bray, M.D.
T. Vyn Reese, M.D.
Angelo Ballasiotes, Pharm.D.
Alvin Goo, Pharm.D.
Jason Iltz, Pharm.D.
Janet Kelly, Pharm.D.
Patti Varley, ARNP

Committee Absence:
John White, Pharm.D.

Quorum was shown for all Pharmacy & Therapeutics Committee motions, 2nd's, and votes.

9:00 a.m. - Committee came to order.

Approval of June 16th Meeting Minutes

- Carol Cordy, M.D. expressed concern regarding the spelling of the words verapamil, pedal edema and intrathecal. Her concerns extended to a comment recorded on page two as being made by Alvin Goo, Pharm.D. and the NSAIDs motions on page three including a comment recorded as belonging to Angelo Ballasiotes, Pharm.D. Dr. Cordy also brought up the differences in the use of the words effective and efficacious, and endorsing prescriber and endorsing practitioner.
- T. Vyn Reese, M.D. mentioned that the word benazepril was misspelled on page four under the heading "ACE Inhibitors".
- Jeff Graham, M.D. explained that regarding the use of the terms effective and/or efficacious the minutes reflect the words used at the time of statement and that if there is a need to change these words within the minutes a vote would need to be invoked.
- Several Committee members felt as if they remembered Skeletal Muscle Relaxants being reviewed at the June 16th meeting and wondered why they had not been included in the minutes. However, the drug review history included in the Committee's materials showed that this drug class had been reviewed and voted upon at the March 17th Committee meeting.
- Erika Clayton stated that regarding the issue of terms endorsing prescribers versus endorsing practitioners the official title is endorsing practitioner.
- Erika Clayton, Duane Thurman, and Jeff Graham, M.D. explained that the minutes are based on the transcription of the tapes and that the motions are verbatim.
- Erika Clayton, Duane Thurman, and Jeff Graham, M.D. assured the P&T Committee that these instances from the June 16th meeting minutes would once again be reviewed and transcribed officially for email distribution and approval at the December 17th meeting.
- The final decision made was that until the corrections to the June 16th meeting minutes were to be approved the current minutes would be posted as final draft minutes subject to approval.
- Duane Thurman also cautioned the Committee regarding such language as the use of the words effective versus efficacious explaining that the motions are literal transcriptions of the tapes and motion templates are available in order to sidestep language complications during the constructing of motions.

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Announcements

- Daniel Lessler, M.D. announced that in regards to the NSAIDs class which was tabled at the previous meeting there is an update in progress and it will be reconsidered at a subsequent meeting
- Jeff Graham, M.D. announced that the final report of Second Generation Anti-Depressants would not be completed until the end of October therefore the special meeting for October 15th has been cancelled. This drug class has been scheduled for the December 15th meeting and a special meeting will be scheduled for January or February in order to stay on schedule.

Statins

Update of Drug Class Review

- Mark Helfand, M.D. of the Oregon Health and Sciences University gave a slide review of the drug class via phone conference.
- T. Vyn Reese, M.D. questioned drug-drug interactions specifically the interaction of the statins with protease inhibitors and cyclosporine and the safest statins to use with those drugs in transplant and AIDS patients. Dr. Reese also inquired as to whether or not there was a difference in risk between fenofibrate and gemfibrozil, which he explained is often a combination used for hyperlipidemia.
- Mark Helfand, M.D. explained that in theory pravastatin and fluvastatin have the lowest potential for interaction in HIV and transplant patients and that atorvastatin, lovastatin, and simvastatin have greatest theoretical potential for clinically important interactions. Fluvastatin possesses a potential for interaction with drugs that inhibit CYP2C9 and pravastatin possesses the lowest potential for interaction with drugs of that kind and the safest in those patients receiving potent CYP inhibitors. Dr. Helfand also admitted that there had been many requests for the report to address the question of fibrates and that there currently was nothing in the report to help clarify the use of fibrates.
- Carol Cordy, M.D. wondered if there were studies conducted concerning statins other than atorvastatin that measured the lowering of CRP [C-reactive protein].
- Mark Helfand, M.D. explained, using the example of a paper from the *Annals of Internal Medicine* to show that studies previous to the PROVE-IT trials had less successful findings in regards to the effect on markers when addressing the rheostatic and anti-inflammatory effects on statins and that with the findings in the PROVE-IT trials there were much more dramatic results in regards to markers of inflammation or of membrane and endovascular stabilization properties. On the other hand, he says that the patients participating in the PROVE-IT trials were those who had recently undergone an MI or a manipulation of a coronary artery with a stent or PTCA and this would be a point where inflammation would be worse than usual even in that same patient with coronary disease and that second interventions would be more likely to make a difference. So, although the previously cited study did not find good correlations with those markers that may not mean that they would be absent in a patient with acute MI. Comparisons of the A-to-Z trial of the simvastatin effect on C - reactive protein to the 80 mg atorvastatin effect in the Prove-It trial may be explored in more detail when the A-to-Z trial is addressed.
- Alvin Goo, Pharm.D. asked for Dr. Helfand's comments on the necessity for 80mg of atorvastatin in the PROVE-IT trial; specifically the analysis that found that patients with a baseline less than 125 had a risk reduction of 7% compared to those with a baseline greater than 125 who had a 34% risk reduction to which he added that this may suggest that maybe not all patients needed a high dose of atorvastatin.
- Mark Helfand, M.D. explained that while the results of the subgroup analyses were important and should be taken into consideration the Committee should understand that these results were from a small group of people and did not contain enough information to make the same assumption of all patients and all statins in all situations.

Stakeholder Input

- Dr. Roy Palmer from Pfizer urged the Committee to continue Lipitor® on the preferred drug list citing trials bearing data such as primary and secondary prevention, data in special populations and safety at both high and low doses.

- Don Hunninghoke, speaking on behalf of Astra Zeneca, testified that rosuvastatin has shown itself to be the most effective for increasing HDL, he cited a few sources which illustrated that rosuvastatin was also beneficial in reaching a secondary goal in non-HDL which is important in groups such as diabetics and those with metabolic syndrome with superior results. Mr. Hunninghoke asked that the Committee consider adding rosuvastatin to the Washington Preferred Drug List as other states have added this drug to their lists.
- Dr. Kevin O'Brien, cardiologist at the University of Washington, spoke on behalf of Astra Zeneca, and commented that while it is true according to several studies that half of patients could achieve an LDL target of 70 with the maximum dose of atorvastatin 80mg, his concern is that the risk for drug-drug interactions and complications is going to be higher than that reported in the trial, and in contrast you can achieve similar reductions in LDL cholesterol and greater increases in HDL with 20mg of rosuvastatin.
- Dr. Ed Gill, cardiologist at University of Washington, based at Harborview Medical Center, urged the Committee to keep atorvastatin on the formulary, citing such trials as Prove It, A-to-Z, and CARDS to show the success of atorvastatin with primary prevention and the lowering of the inflammatory state of acute coronary syndrome.
- Mark Helfand, M.D. responded in order to clarify that while atorvastatin is proven in primary prevention he was referring to low risk population primary prevention as opposed to relatively moderate or high risk primary prevention. Dr. Helfand commented that in regards to CRP, Astra Zeneca, the maker of rosuvastatin, is currently conducting a study involving a population with no indication for statin and an elevated CRP randomized to rosuvastatin and placebo. He also added that the comparisons of the A-to Z and Prove It trials are not as direct as they could be and what is needed to make a statement of the anti-inflammatory effects in the situation of post and peri-MI would be a study that compared higher not lower doses of simvastatin or rosuvastatin to that of the higher dose of atorvastatin.
- An Pham of Reliant Pharmaceuticals asked that the Committee recommend Lescol® and Lescol xl® for the PDL for the considerations of safety, efficacy, tolerability at 80 mg, lack of drug interaction and the important use in special populations such as transplant and HIV patients.
- Dr. Bradley Bale, who manages a heart attack prevention clinic, spoke on behalf of Bristol Meyers Squibb and encouraged the continuation of pravastatin on the formulary citing many sources including a paper by Dr. Steve Nissen promoting intensive LDL reduction along with the activation of the HDL pathways using such medications as niacin, fibrates, TZD, bile acid sequestriants and Zetia® in combinations with the statins.

Committee Deliberation & Vote

- Daniel Lessler, M.D. suggested entering into a discussion in order to generate ideas before constructing the Statins motion.
- Jason Iltz, Pharm.D. asked Dr. Helfand to comment on the article by VIDT, broached earlier in the discussion, which shows all statins to have some incidence of proteinuria.
- Mark Helfand, M.D. while not familiar with the article, did divulge that no statement of understanding had been made regarding the significance of the rates of proteinuria from rosuvastatin in the FDA materials, he then noted that while FDA did approve this drug, up to 2% of the patients on rosuvastatin may need to have their dose reduced due to proteinuria.
- Ashley Jefferson, M.D., nephrologist at the University of Washington, encouraged the addition of atorvastatin to the PDL in regards to the efficacy and CFD data. He also explained that atorvastatin is often used in patients with kidney disease who have impaired renal function and atorvastatin does not need alteration in dosage as opposed to other statins which would need alteration in the event of impaired renal function.
- Ted Kapanje, M.D., family practitioner, testified that Crestor® is used in over half of his patients and he feels very strongly that this drug should be added to the PDL.
- Daniel Lessler, M.D. again suggested an informal brainstorming session before crafting the final motion; he also encouraged discussion by asking for the Committee's thoughts on approaching the motion structure.
- T. Vyn Reese, M.D. commented that statins are a challenging group and there is a need for three statins; one high potency, one low potency, and one safe statin with little drug interaction unless the Committee can find a way to identify patients on drugs that have the potential for major drug interaction with the P450 system.
- Siri Childs, Pharm.D. announced the drugs currently on the PDL as atorvastatin, lovastatin, and pravastatin

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- Jeff Thompson, M.D. explained that through MAA if a patient does need a statin that the drug would be made available to them after their physician explained their patient's special need.
- Robert Bray, M.D. suggested that a high potency choice would work for people who don't need as much LDL reduction.
- Carol Cordy, M.D. addressed MAA and asked for clarification regarding Dr. Thompson's earlier statement about acquiring drugs through a phone call specifying a patient's special needs. She explained that phone calls are time consuming and inquired whether or not it was possible to acquire these drugs by written indication on the prescription.
- Jeff Thompson, M.D. explained that according to SB6088 an Endorsing Practitioner could write DAW on a prescription making any drug available to the patient.
- Carol Cordy, M.D. wanted to know what the procedure is if the practitioner is not endorsing.
- Siri Childs, Pharm.D. explained that if the practitioner is not endorsing but indicates on the prescription the reasons why this patient should receive a non-preferred drug the phone call would then be made by the pharmacy to MAA, however, the patient must have tried and failed a preferred drug before the non-preferred may be made available.
- Daniel Lessler, M.D. asked the Committee to share their thoughts on a possible group of medicines consisting of atorvastatin, lovastatin and pravastatin.
- Duane Thurman suggested that the Committee consider their formulary decisions within the context of those who have endorsed the Washington State Preferred Drug List; these would be practitioners who would have no need to make phone calls and instead would be indicating DAW and automatically receiving the non-preferred drug.
- Jason Iltz, Pharm.D. suggested considering lower dose of higher potency statins in order to reduce possible side effects.
- T. Vyn Reese, M.D. suggested considering the patients whose need for LDL reduction is less and the risk for higher dose statins is higher, that combination therapy is something to avoid and that a higher potency statin may make combination therapy less necessary.
- Janet Kelly, Pharm.D. expressed her concern regarding the safety of rosuvastatin specifically in regards to nephropathy; she does not encourage the placement of this drug on the preferred drug list.
- Daniel Lessler, M.D. agreed with Dr. Kelly and supported her statement by mentioning that there had not been enough definitive outcome data associated with this drug to assure adequate benefit.
- Jason Iltz, Pharm.D. summarized the VIDT article which he felt addressed the problem of proteinuria with statins: all statins have some sort of proteinuria with them and statins may be renal protective in that a small decrease in serum creatinine was seen with all statins. He added that he felt the availability of more potent statins with ability to prescribe in lower doses would help other side effects.
- Jeff Thompson, M.D. requested that the Committee clarify within the motion which drugs are cited for specific diseases and individual drugs within a subclass, as it would help staff when they were ready to review cost effectiveness.
- Duane Thurman requested that the Committee recommend which drugs can be appropriately interchanged for those not considered preferred.
- Jason Iltz, Pharm.D. asked where a combination drug might fit on the formulary.
- Jeff Graham, M.D. announced that a policy on combination drugs would soon be released and that because the Evidence Based Practice Center would not be reviewing combination drugs they would not be considered within the drug classes, as it is not known that they can be interchanged. He added that while combination drugs may appear on individual agencies preferred drug lists they would not appear on the Washington State Preferred Drug List.
- Daniel Lessler, M.D. recommended considering a high potency drug, such as rosuvastatin or atorvastatin, be included on the formulary with respect to LDL lowering, primary and secondary prevention and lack of interaction with P450.
- Robert Bray, M.D. is expressed concern with making the motion more complicated than necessary and suggested a simpler structure in which the Committee approaches three categories; higher potency, lower potency and special population in regards to the CYTP450 system as these drugs can be used in various ways.
- Jason Iltz, Pharm.D. commented that he would like to specify what effect making a drug interchangeable has on the Therapeutic Interchange Program and how the Committee can be sure that drugs are being interchanged with other drugs of equivalent dose.
- Jeff Thompson, M.D. explained that after a drug has been established on the formulary as interchangeable the responsibility of the appropriate interchange then lies with the prescriber and the pharmacist.
- T. Vyn Reese, M.D. added that Dr. Helfand had a table listing interchangeable drugs and their equivalent doses.

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- Siri Childs, Pharm.D., mentioned that pravastatin was currently on expedited prior authorization for a specific sub-population of those patients with a drug/drug interaction and that the two statins available for interchange were atorvastatin and lovastatin.
- Jeff Graham, M.D. clarified Dr. Childs' statement by explaining that atorvastatin and lovastatin are drugs that would be the result of an interchange rather than drugs that would be interchanged for one another.
- Donna Marshall, Pharm.D. explained that while Medicaid does have pravastatin on expedited prior authorization, UMP considers pravastatin to be a preferred drug with no restrictions.
- Carol Cordy, M.D. commented that the Committee would be complicating and confusing things by establishing three different categories. She also mentioned the letters received when practitioners prescribed non-preferred drugs.
- Siri Childs, Pharm.D. stated that she would take care of the issue of the letters.
- Daniel Lessler, M.D. encouraged Robert Bray, , M.D. to begin the making of the motion.
- Robert Bray, M.D. commented that there would be difficulty in deciding which of the high potency drugs the Committee feels are therapeutically interchangeable. In particular, issues of lack of outcome studies and safety questions with rosuvastatin as a high potency drug and whether or not it is interchangeable with atorvastatin. Pravastatin seems to be the choice for special population in metabolism, however, it is a mid or lower potency drug. He added that there was no reason why pravastatin could not be considered for two categories; the lower potency and the special population for the P450 system. Robert Bray, , M.D. prefaced his motion suggestion by saying that there is significant concern regarding the potential interchange of atorvastatin and rosuvastatin. Dr. Bray then makes a tentative motion as follows: After considering the evidence of safety, efficacy and special populations, I move that atorvastatin is safe and effective in the consideration of a high potency statin and that it not be subject to therapeutic interchange with other drugs on the Washington Preferred Drug List.
- Donna Marshall, Pharm.D. requested a clarification of his motion suggestion.
- Robert Bray, M.D. clarified his suggested motion by explaining that if the Committee is to establish categories such as high potency there should be a declaration within the motion of which drugs are high potency. He also referred to earlier in the discussion when the Committee decided that there were three statins that could be considered high potency, however, he did not feel that the three statins mentioned were interchangeable with one another and so he proposed that the high potency drug included in the sub-list be atorvastatin.
- Daniel Lessler, M.D. suggested a motion that recognized a need for one high potency and one low potency drug: "with respect to high potency we find that atorvastatin is safe and efficacious and with respect to low potency we find that X, Y and Z are efficacious and finally that we recommend there be one medication that does not interact with the P450 system".
- Daniel Lessler, M.D. made a friendly amendment to the suggested motion: "we recommend that there be a high potency alternative statin available on the formulary and with respect to a high potency statin we find that atorvastatin is safe and efficacious. We also recommend that low potency alternatives be available and we find that simvastatin, pravastatin, lovastatin and fluvastatin are safe and efficacious and we further recommend that a statin that does not interact with the P450 system be available on formulary".
- Donna Marshall, Pharm.D. inquired whether Dr. Daniel Lessler, , M.D. intended there to be three different motions or one motion encompassing the three categories.
- Daniel Lessler, M.D. commented that there could be three different motions, the first being that a high potency statin be made available on the PDL and that the Committee find atorvastatin to be safe and efficacious in this regard.
- Janet Kelly, Pharm.D. suggested that the Committee should first state that the following statins as safe and efficacious; lovastatin, pravastatin, simvastatin, atorvastatin and then go on to say that a high potency agent needs to be available and then recommend that that agent be atorvastatin and that a statin with no P450 interactions be available, namely pravastatin. She explained that using this structure would make it easier to identify which drugs were specified for high potency and which for special populations and which drugs were available for low potency. Motion: I move the following statins lovastatin, pravastatin, simvastatin, atorvastatin, and fluvastatin be on the preferred drug list which must include a high potency option and we recommend atorvastatin for that, we also must include a statin with minimal P450 interaction and pravastatin is recommended for that.
- The Committee recognized that fluvastatin was unintentionally excluded from the motion while rosuvastatin was intentionally excluded.

- Daniel Lessler, M.D. suggested a few edits to the motion in order to lessen the bulky language.
- Patti Varley, ARNP commented that the language of the motion should read "the Washington Preferred Drug List must include" rather than "we recommend the Washington State Preferred Drug List include".
- Daniel Lessler, M.D., Carol Cordy, M.D. and Janet Kelly, Pharm.D. voiced agreement that the language should read "must include".
- Alvin Goo, Pharm.D. suggested that the language should read "minimal P450" and the correction was made.
- Daniel Lessler, M.D. instructed that the motion be read back.
- Janet Kelly, Pharm.D. read back the motion as it was displayed by the projector: "After considering the evidence of safety, efficacy and special populations, I move that the following statins are safe and efficacious atorvastatin, fluvastatin, lovastatin, pravastatin, and simvastatin and can be subjected to therapeutic interchange in the Washington Preferred Drug List. The PDL must include atorvastatin as a high potency option and the PDL must include pravastatin as an alternative with minimal cytochrome P450 drug interactions".

  2nded: T. Vyn Reese, M.D.
- Carol Cordy, M.D. asked if a motion structured in this way would save prescribers from having atorvastatin interchanged with one of the low potency statins.
- Donna Marshall, Pharm.D. explained that this motion stated that atorvastatin and pravastatin must be on the list so the agency directors would then have the option of choosing only atorvastatin and pravastatin or those two drugs and any combination of the other three listed.
- Patti Varley, ARNP also voiced the concern that the language of the motion is confusing in regards to which drugs can be subjected to Therapeutic Interchange.
- Further discussion between Daniel Lessler, M.D., Donna Marshall, Pharm.D. Carol Cordy, M.D., Siri Childs, Pharm.D. and Jeff Graham, M.D. regarding the correct language of the motion and the intention of the drugs subjected to Therapeutic Interchange.
- Daniel Lessler, M.D. suggested that Janet Kelly, Pharm.D. read back the amended motion.

> **Motion:** [Kelly] After considering the evidence of safety, efficacy and special populations, I move that the following statins are safe and efficacious atorvastatin, fluvastatin, lovastatin, pravastatin, and simvastatin. The Washington Preferred Drug List must include atorvastatin as a high potency option and pravastatin as an alternative with minimal cytochrome P450 drug interactions and are not subject to therapeutic interchange. The other listed drugs may be subject to therapeutic interchange.
> **2nded:** T. Vyn Reese, M.D.

- Jason Iltz, Pharm.D. commented that by excluding rosuvastatin the Committee appeared to be saying that there is evidence that is showing that it is unsafe or ineffective.
- Daniel Lessler, M.D. replied by saying that the exclusion could also mean that there is no evidence showing that rosuvastatin is effective.
- Robert Bray, M.D. commented that because rosuvastatin does not have enough market history to answer certain questions regarding safety as well as its issues of less outcome data he does not feel that rosuvastatin can be therapeutically interchanged with atorvastatin and it is for these reasons that he initially excluded rosuvastatin. He makes it clear that he is not trying to censure rosuvastatin as being unsafe.
- Jason Iltz, Pharm.D. suggested that this idea should be included in the motion so as not to imply that the Committee finds rosuvastatin to be unsafe and ineffective. He also commented that Dr. Helfand's presentation produced data that stated that there were no significant differences among the statins, including differences in safety.
- Robert Bray, M.D. commented that Dr. Helfand's presentation shows that there is increased frequency of proteinuria in rosuvastatin and that they have asked for further information regarding the drug.
- Angelo Ballasiotes, Pharm.D., commented that he would like rosuvastatin addressed in terms of safety.
- Daniel Lessler, M.D. suggested a vote on the motion read.
- Donna Marshall, Pharm.D., suggested a change to the motion language that would make reference only to those drugs included in the long term outcome studies in which rosuvastatin was not included.

- Daniel Lessler, M.D. commented that he does not feel that it is necessary to amend the language of the motion, as it did not mention rosuvastatin at all.
- Robert Bray, M.D. commented that through the language of the motion he does not feel as if the Committee has claimed that rosuvastatin is unsafe or not efficacious.
- T. Vyn Reese, M.D. encouraged the call for a vote.
- Daniel Lessler, M.D. then called for the vote.
- Robert Bray, M.D. began a discussion regarding the language of the motion and the effect of the therapeutic interchange.
- Donna Marshall, Pharm.D. explained the process of the therapeutic interchange program and how the motion might work in regards to preferred and non-preferred drugs.
- Siri Childs, Pharm.D. urged the Committee to consider the last sentence of the motion.
- Jeff Graham, M.D., disagreed and clarified that the motion reads that atorvastatin can never be interchanged for anything and that pravastatin can never be interchanged for anything as long as it meets the criteria stated, but that the other drugs listed may be interchanged for one another.
- Donna Marshall, Pharm.D explained that the interchange is made when a prescribed drug is changed to a drug that is preferred and that it is not the act of the preferred drug that is actually dispensed. She adds that the interchange is against the non-preferred drug that is prescribed not the preferred drug that is dispensed.
- Jeff Graham, M.D. made a clarification regarding the statement from the motion reading "not subject to therapeutic interchange" to mean that it will never be interchanged.
- Voices of concern and confusion continue.
- Donna Marshall, Pharm.D. then reads the definition of therapeutic interchange.
- Carol Cordy, M.D. clarified that the motion stated that any of the five drugs could be substituted for each other except atorvastatin and pravastatin.
- Daniel Lessler, M.D. reiterates that the motion has been seconded and calls for a vote.

Vote: Majority rules
Three dissenting votes; Alvin Goo Pharm.D, Jason Iltz, Pharm.D, and Angelo Ballasiotes, Pharm.D.
John White, PA, Pharm.D. was absent

The following is a testament from a stakeholder who spoke to the use of a specific form of Estrogens, however, in the interests of time she was permitted to speak before this drug class was introduced.

- Pat Kulpa, gynecologist, urged the Committee to consider transdermals over oral estrogens as it would better benefit those patients with hepatitis and hypertension as well as post-operative patients.

PPIs

In the interests of time a stakeholder was allowed to speak before the Proton Pump Inhibitors presentation was given

- Peter Hartwell, gastroenterologist at Highline Hospital, testified to the positive effects of esomeprazole.

Update of Drug Class Review

Due to a conference call number issue the Committee was initially unable to connect to Marian McDonough for the purposes of the slide review

- Daniel Lessler, M.D., presented the first third of the slide review, Marian McDonough Pharm.D., once contacted, completed the presentation.
- Alvin Goo, Pharm.D., requested clarification regarding the findings from the unpublished esomeprazole studies showing no benefit between esomeprazole and omeprazole.

- Marian McDonough, Pharm.D. explained that there were mixed results in the esomeprazole studies and that the report did include the fully published studies showing a significant benefit of esomeprazole over omeprazole. The two studies that did not show a significant benefit were not included as they did not meet the inclusion criteria due to inadequate information. She added that there was a paragraph in the report that mentioned all four studies but that she did not mention them in her presentation as they could not be fully included.

Stakeholder Input

- Bob Snettiker with Jansen Pharmaceuticals spoke in favor of Aciphex®, specifically regarding the cost saving effects of its intermittent use. He also cited data speaking to its positive effects on GERD and *Helicobacter pylori (H. pylori.)*
- Wayne Anderson, Regional Director of Scientific Affairs at Astra Zeneca, presented information that he believed should be contained within the next report on PPI's released in the fall of 2004. He cited data showing that the population of Washington State residents suffering from severe complications of a reflux disease would benefit from a more powerful PPI such as esomeprazole.
- Mark Shigahara, Regional Account Manager of Managed Care for Wyeth and assistant professor at the University of Washington School Of Pharmacy, stated that pantoprazole has had a commanding market share within the state. He then asked Siri Childs, Pharm.D., Pharmacy Director of MAA, for confirmation for historical purposes.
- Siri Childs, Pharm.D. confirmed his statement.
- Mark Shigahara went on to say that pantoprazole was one of the few agents presented in a standard 40 mg dosage form and can be given without regard to meals and is also available in injectable format so that patients transferring from an IV product to this form of pantoprazole have an easier dosage conversion.

Committee Deliberation and Vote

- Jeff Graham, M.D. commented that one point that should be brought to the Committee's attention was that during the last review of PPI's the special populations that do not have adverse events but do need special delivery systems such as pediatrics and the elderly had not been considered.
- Daniel Lessler, M.D. suggests using the past PPI motion as a starting point for motion constructing.
- Donna Marshall, Pharm.D. read back the previous motion stating that "no evidence that any PPI is safer or more efficacious than any other" and she added that there was no direction to specify liquid preparation.
- Dan Lessler, M.D., read back the same motion indicating that T. Vyn Reese, , M.D. brought about the motion.
- T. Vyn Reese, M.D., commented that no new evidence had been brought forward therefore the old motion was still valid.
- Robert Bray, M.D. suggested that the Committee add to the motion to include liquid formulation regarding issues of pediatrics.
- Donna Marshall, Pharm.D. commented that there are products that dissolve on the tongue that may also be helpful in patients who have difficulty swallowing.
- Robert Bray, M.D. commented that he did not feel that the dissolving tablets were safe in infants and that the motion would have to include a liquid form.
- Siri Childs, Pharm.D. asked if someone from TAP was present at the meeting, she went on to say that the liquid formulation will be discontinued and their product, Prevacid Solutab®, can be liquefied by adding water.
- Matt Keim from TAP Pharmaceuticals informed the Committee that the original Prevacid®oral suspension would be discontinued and he added that there was an oral disintegrating tablet (Prevacid Solutab®) that can be used in pediatrics.
- Robert Bray, M.D., asked Matt Keim to clarify the product.
- Siri Childs, Pharm.D. and Matt Keim answered "Prevacid" nearly in unison. Jeff Graham, , M.D., Siri Childs, Pharm.D. and Donna Marshall, Pharm.D. all added "SoluTabs, lansoprazole?"
- Jeff Graham, M.D. commented that the Committee could just direct the staff that those products can be made available in special populations.

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- An unidentified Medical Information Scientist from Astra Zeneca announced that Astra Zeneca's capsules can be opened and placed in applesauce or suspended in common beverages such as applesauce and orange juice. The capsule can also be suspended in water and placed on a Naso-Gastric (NG) tube. She added that she had submitted information with references showing its bioavailability and stated that their product is similar to that of the dissolving product.
- T. Vyn Reese, M.D. announced that he was ready to make his motion. After considering the evidence of safety, efficacy and special populations, I move that rabeprazole, omeprazole, lansoprazole, pantoprazole, and esomeprazole are safe, effective and have no adverse events in special populations. They can be subject to therapeutic interchange in the Washington Preferred Drug List. A liquid formulation needs to be available on the state formulary.
- Carol Cordy, M.D. questioned the motion template in regards to the words "are safe…" she wanted to know if should read "equally safe".
- T. Vyn Reese commented that they are "safe, effective and have no adverse events".
- Carol Cordy, M.D. commented that "effective" should be changed to "efficacious".
- Daniel Lessler, M.D. agreed.
- Janet Kelly, Pharm.D. suggested that the motion not specify "liquid" as the TAP representative mentioned that liquid would be discontinued in the future and instead read something to the effect of "a formulation can be given to pediatrics..."
- T. Vyn Reese, M.D. asked Siri Childs, Pharm.D. how she would prefer the Committee word that idea.
- Siri Childs, Pharm.D. responded that she thought there should be an indication for pediatric use.
- T. Vyn Reese, M.D. decided it should be worded as follows "a pediatric formulation needs to be included".
- Janet Kelly commented that there may also be adults who would be in need of an alternative dosage form.
- Siri Childs, Pharm.D. commented that the pediatric formulation would work for them as well.
- Daniel Lessler, M.D. instructed T. Vyn Reese, , M.D. to read the amended motion.
- Dr. Reese read: After considering the evidence of safety, efficacy and special populations, I move that rabeprazole, omeprazole, lansoprazole, pantoprazole, and esomeprazole are safe, efficacious and have no adverse events in special populations. They can be subject to therapeutic interchange in the Washington preferred drug list. A pediatric formulation needs to be included on the Washington Preferred Drug List.
- Carol Cordy, M.D. questioned the phrase "no adverse events".

The motion was changed as follows:

> **Motion:** [Dr. Reese] After considering the evidence of safety, efficacy and special populations, I move that rabeprozole, omeprazole, lansoprazole, pantoprazole, and esomeprazole are safe, efficacious and have no differences in adverse events in special populations. They can be subject to therapeutic interchange in the Washington preferred drug list. A pediatric formulation needs to be included on the Washington Preferred Drug List.
> **2nded**: Robert Bray, M.D.
> **Vote:** Unanimous
> John White, PA, Pharm.D. was absent

ESTROGENS

Update of Drug Class Review

- The Committee was unable to contact Marian McDonough by phone and so Daniel Lessler, M.D. presented the Estrogen slide review to the Committee.

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Stakeholder Input

- Lori Haworth, Rph., a registered pharmacist with Burlex Laboratories, encouraged the Committee to consider the use of transdermal estrogens citing many sources including the guidelines of the American Association of Clinical Endocrinologists for Management of Menopause, the North American Menopause Society and a study by Ettinger *et. al.* of which demonstrated that transdermal estrogen therapy was more beneficial than oral estrogen therapy.
- Mark Shigahara urged the Committee to consider the Premarin® and Prempro® products as part of an evidence based formulary.
- Daniel Lessler, M.D. asked the Committee if there were any modifications to be made to the previous recommendation. After receiving no answer he then asked the Committee to make a motion.
- T. Vyn Reese, M.D. volunteered Jason Iltz, Pharm.D., as he was originator of the previous estrogen motion.

> **Motion:** [Iltz] After considering the evidence of safety, efficacy and special populations, I move that estradiol valerate (oral); esterified estrogen (oral); estropipate (oral); synthetic conjugated estrogen (oral); conjugated equine estrogen (oral and vaginal cream); 17-beta estradiol (oral, transdermal, vaginal cream, and intravaginal ring) are safe, efficacious and have no adverse events in special populations and can be subject to therapeutic interchange in the Washington preferred drug list.

- Unidentified speakers suggested the words "no differences identified in adverse events" in place of "have no adverse events".
- Jeff Thompson, M.D., requested clarification regarding the Committee's intention to include the combination agents.
- Dr. Lessler replied negatively.
- Jeff Thompson, M.D. stated that they were included in the OHSU Review.
- Siri Childs, Pharm.D. informed Jeff Thompson, M.D. that they were not listed in the current summary.
- Jeff Thompson, M.D. replied that they were listed in the first summary.
- Jason Iltz, Pharm.D. amended the motion with input from Donna Marshall, Pharm.D. and Daniel Lessler, M.D. reading the previous Estrogen motion.

> **Motion:** [Iltz] After considering the evidence of safety, efficacy and special populations, I move that estradiol valerate (oral); esterified estrogen (oral); estropipate (oral); synthetic conjugated estrogen (oral); conjugated equine estrogen (oral and vaginal cream); 17-beta estradiol (oral, transdermal, vaginal cream, and intravaginal ring) are efficacious and have no differences in efficacy identified in special populations for the indication of menopausal symptoms and can be subject to therapeutic interchange in the Washington preferred drug list. There is insufficient evidence available to compare the relative safety of the estrogen products at this time. The Committee recommends that practitioners prescribe the lowest effective dose of the particular estrogen product prescribed.

- Carol Cordy, M.D. asked what the Committee's understandings of menopausal symptoms were.
- Daniel Lessler, M.D. commented that that point had been previously covered and asked if there would be a second to Dr. Iltz's motion.

> **2nded:** Alvin Goo, Pharm.D.
> **Vote:** Unanimous
> John White, PA, Pharm.D. was absent

4:15 Meeting adjourned.